BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: OLIVER CHENG-TUNG TSAI, M.D., Physician's and Surgeon's Certificate Number A49033, Respondent.	Case No. 800-2017-034074 OAH No. 2018070055

DECISION AFTER NON-ADOPTION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Los Angeles, California, on January 2, 2018.

Richard D. Marino, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).

Steven M. Cron, Attorney at Law, represented Oliver Cheng-Tung Tsai, M.D. (Respondent).

Complainant seeks to revoke probation and impose the stayed revocation of Respondent's medical license on the grounds that he failed to pass the Physician Assessment and Clinical Education Program at the University of California, San Diego (PACE). Respondent denies that he lacks the competency to practice medicine, asserts that he knows why he did not pass before and that he is now better prepared to retake the examination, and wishes another opportunity to successfully complete the PACE Program. As set forth below, it was established that Respondent violated probation by failing to successfully complete the PACE Program.

Oral and documentary evidence was received at the hearing, and the matter was submitted for decision on January 2, 2018.

On April 27, 2018, Panel B (Panel or Panel B) of the Board issued an Order of Non-Adoption of the Proposed Decision. On July 10, 2018, the Panel issued a Notice of Hearing for Oral Argument for July 26, 2018. Respondent did not submit written argument regarding this matter and neither he nor his counsel were present at the hearing. Complainant, through her counsel, submitted written argument but no oral argument was offered. Therefore, on July 26,

2018, after a quorum of the Panel was established, Panel B did not hear oral argument as there was none offered. The Panel then moved into closed session to deliberate on the matter.

Having read and considered the administrative record and the written argument submitted by complainant, the Panel hereby makes and enters the following as its decision in this matter.

FACTUAL FINDINGS

1. Complainant filed the Petition to Revoke Probation on August 29, 2017, in her official capacity.

2. On December 17, 1990, the Board issued Physician's and Surgeon's Certificate Number A 49033 to Respondent.

3. Respondent was born in Taiwan, where he graduated from medical school. He immigrated to the United States in 1988. In 1992, he completed a three-year rotating internship at State University of New York Downstate Medical Center in Brooklyn, New York. His area of practice is internal medicine.

4. On July 5, 2016, Respondent entered into a Stipulated Settlement and Disciplinary Order (Disciplinary Order), in which his medical license was placed on probation for five years on certain terms and conditions. One of the terms, Condition number 5, required Respondent to enroll in the PACE Program or an equivalent program not later than 60 days after the effective date of the Board's decision adopting the Disciplinary Order. Failure to successfully complete the PACE Program would require Respondent to cease the practice of medicine until a final decision was rendered on an accusation or petition to revoke probation. stemming from the failure to successfully complete the clinical program. The Board adopted the Disciplinary Order, which became effective on October 28, 2016.

5. In the Disciplinary Order, Respondent stipulated that at hearing Complainant could establish a factual basis for the charges in a then-pending accusation, that, if proven, the charges constituted cause for discipline, that he gave up his right to contest the allegations, and that if he ever filed a petition for reinstatement the allegations would be deemed true. The accusation alleged that Respondent engaged in excessive prescribing, prescribed controlled substances without an appropriate physical examination or medical indication, prescribed controlled substances to addicts, violated applicable drug laws, engaged in gross negligence, engaged in repeated negligent acts, was incompetent, failed to maintain adequate records, and engaged in unprofessional conduct in connection with his care and treatment of eight patients, and that he suffered a criminal conviction substantially related to the practice of medicine.

6. a. Respondent participated in Phase I of the PACE Program on December 19 and 20, 2017. As part of Phase I, Respondent: underwent physical and mental evaluation, which included a cognitive screening test, the Microcog; completed a history and physical examination on a mock patient; participated in an oral clinical examination; provided a random sample of charts for review; reviewed cases presented through the computerized program PRIMUM; underwent a Transaction Simulated Recall (TSR) interview based on the cases presented in PRIMUM; took multiple choice examinations created by the National Board of Medical Examiners (NBME) and completed other written tests; and participated in an exit interview.

b. PACE physicians described Respondent's performance at the conclusion of Phase I as "varied." (Exh. 7, at p. 9.) Respondent performed very well in the oral competency examination, correctly diagnosed all eight cases in PRIMUM, and demonstrated good medical knowledge and clinical judgment in the TSR interview. However, his sample charts were in need of significant improvement. His performance of the history and physical exam and his write-up of the mock encounter were unsatisfactory. Physical examination revealed diminished hearing, and follow up with an audiologist was recommended. While not suggesting significant cognitive impairment, some deficits were revealed through the Microcog screening test and PACE recommended further mental evaluation. PACE also recommended that Respondent study a specified website to remediate deficiencies in history and physical examination skills.

7. On February 27, 2017, Board Inspector Sandra Borja (Borja) informed Respondent about PACE's recommendation for further study at the cited website. She informed Respondent that the Board will wait until completion of Phase II of the PACE Program before making any judgments about competence.

8. a. Respondent participated in Phase II of the PACE Program on May 1 through May 5, 2017. He spent 38 hours shadowing seven participating internal medicine faculty at University of California, San Diego, clinics. Respondent had the opportunity to participate in the care of patients with a wide variety of conditions and was asked questions about the patients by the treating physicians. The PACE physician overseeing the Phase II assessment, Dr. Cederquist, performed what he called a "Chart Simulated Recall (CSR) Exercise," in which he asked Respondent detailed questions about seven of Respondent's 20 randomly selected patient charts.

b. Respondent was given two additional tests in light of history and physical examination deficiencies identified in Phase I. He repeated the mock history and physical examination, and his performance was satisfactory. Respondent also successfully completed a history and physical examination practicum.

c. In summarizing the comments of the seven physicians Respondent observed during his clinical rounds, Dr. Cederquist concluded that Respondent's performance was "very mixed." (Exh. 7, at p. 12.) Some of the faculty felt Respondent performed in a satisfactory manner, but a few identified significant deficiencies. Of concern was Respondent's ability to reason through the more difficult cases. In administering the CSR, Dr. Cederquist described Respondent's documentation as unsatisfactory and his medical decision-making as substandard.

9. On June 19, 2017, PACE issued its final report, concluding that Respondent had failed the PACE Program and opining that he could not safely practice medicine. In the view of PACE clinicians, despite possessing the requisite knowledge, Respondent was unable to consistently deploy such ability in the actual practice of medicine. PACE evaluators concluded: "We are unsure what is causing [Respondent] to perform in an unsafe manner. There are several possible explanations including a cognitive disorder, sociopathy, and a substance abuse disorder. However, determining why [Respondent] is not performing safely is beyond the scope of a competence evaluation. To further investigate the causes of [Respondent]'s inability to practice safely, we recommend that he undergo a neuropsychological evaluation (described on pages 2-3 of this report), psychiatric evaluation and toxicology screening." (Exh. 7, at p. 19.)

10. On June 20, 2017, Borja informed Respondent that he had not successfully completed the PACE Program and that the matter was being referred to the Attorney General's Office with a request to pursue disciplinary action against Respondent's license. Borja also informed Respondent of PACE's recommendation for neuropsychological evaluation, psychiatric evaluation, and toxicology screening.

11. On July 11, 2017, Complainant issued a Cease Practice Order, prohibiting Respondent from practicing medicine until a final decision is rendered on an accusation or petition to revoke probation.

12. Respondent underwent the testing and assessment recommended by PACE, and has successfully passed all tests. On June 30 and July 7, 2017, David C. Anderson, Ph.D. (Anderson), conducted a neuropsychological fitness for duty evaluation. Dr. Anderson's testing did not reveal any cognitive impairment. In Dr. Anderson's opinion, Respondent is able to function effectively as a physician and in a manner conducive to public safety. On July 14, 2017, Nathan E. Lavid, M.D., conducted a comprehensive psychiatric evaluation of Respondent and concluded that Respondent's ability to safely practice medicine was not impaired by any psychiatric condition. Respondent was also examined by an audiologist, and hearing aids were not required.

13. Respondent has ceased practicing medicine, as ordered by Complainant. He has continued to study the medical literature to maintain his knowledge, spending about 30 hours per week in this endeavor. He recognizes his record keeping deficiencies and has completed a course to improve in this area. He has a better understanding of what is expected of him to show that he can use his knowledge in the actual treatment of patients.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving, by clear and convincing evidence to a reasonable certainty, that cause exists to discipline Respondent's physician's and surgeon's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1985) 135 Cal.App.3d 853, 856.) This means that the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal –so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) Complainant has met this burden of proof.

2. Cause exists to revoke probation and to impose the stayed penalty of revocation because Respondent failed to successfully complete the PACE Program as required by Condition number 5 of the Disciplinary Order, by reason of factual finding numbers 4 through 9.

3. The purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476).

4. All evidence presented at the hearing has been considered. Despite failing to successfully complete the PACE Program, Respondent passed many (but not all) of the program's components. He does not suffer from any physical or mental condition that would impair his ability to practice medicine. His base of knowledge does not seem to be an issue, and Respondent has a better

understanding of what is expected of him to show that he can use such knowledge in the actual treatment of patients.

5. Public protection is the paramount priority of the Board and therefore the Panel, whenever exercising its licensing, disciplinary or regulatory functions. When making a disciplinary decision, the Panel shall consider its *Disciplinary Guidelines*. (See Cal. Code Regs, tit. 16, § 1361. The Board's *Guidelines* set forth the expectation that if a physician fails a clinical competency assessment program ordered as part of his or her probation, revocation shall be ordered. (See Manual of Model Disciplinary Orders and Disciplinary Guidelines (2016), p. 28.) After reviewing the record, the Panel is not persuaded to deviate from this expectation. Accordingly, to protect the public, Respondent's certificate is revoked.

ORDER

The Petition to Revoke Probation is sustained. Accordingly, Certificate No. A49033 issued to Respondent OLIVER CHENG-TUNG TSAI is revoked.

This Decision shall become effective at 5:00 pm on September 14, 2018.

IT IS SO ORDERED August 15, 2018.

KRISTINA D. LAWSON, J.D., CHAIR
PANEL B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against:	)	
Oliver Cheng-Tung Tsai, M.D.	)	Case No.: 800-2017-034074
Physician's & Surgeon's Certificate No: A 49033	)	OAH No.: 2017090953
Respondent	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Jilio-Ryan Court Reporters, 14661 Franklin Avenue #150, Tustin, CA 92780. The telephone number is 714-424-9902.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
916-263-2442
Attention: Jody Wright

Date: April 27, 2018

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: OLIVER CHENG-TUNG TSAI, M.D., Physician's and Surgeon's Certificate Number A 49033, Respondent.	Case No. 800-2017-034074 OAH Case No. 2017090953

PROPOSED DECISION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in Los Angeles, California, on January 2, 2018.

Richard D. Marino, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).

Steven M. Cron, Attorney at Law, represented Oliver Cheng-Tung Tsai, M.D. (Respondent).

Complainant seeks to revoke probation and impose the stayed revocation of Respondent's medical license on the grounds that he failed to pass the Physician Assessment and Clinical Education Program at the University of California, San Diego (PACE). Respondent denies that he lacks the competency to practice medicine, asserts that he knows why he did not pass before and that he is now better prepared to retake the examination, and wishes another opportunity to successfully complete the PACE Program. As set forth below, it was established that Respondent violated probation by failing to successfully complete the PACE Program, but the stayed revocation will not be imposed; instead, Respondent shall remain on probation on the existing terms and will be given a second opportunity to complete the PACE Program.

Oral and documentary evidence was received at the hearing, and the matter was submitted for decision on January 2, 2018.

FACTUAL FINDINGS

1. Complainant filed the Petition to Revoke Probation on August 29, 2017, in her official capacity.

2. On December 17, 1990, the Board issued Physician's and Surgeon's Certificate Number A 49033 to Respondent.

3. Respondent was born in Taiwan, where he graduated from medical school. He immigrated to the United States in 1988. In 1992, he completed a three-year rotating internship at State University of New York Downstate Medical Center in Brooklyn, New York. His area of practice is internal medicine.

4. On July 5, 2016, Respondent entered into a Stipulated Settlement and Disciplinary Order (Disciplinary Order), in which his medical license was placed on probation for five years on certain terms and conditions. One of the terms, Condition number 5, required Respondent to enroll in the PACE Program or an equivalent program not later than 60 days after the effective date of the Board's decision adopting the Disciplinary Order. Failure to successfully complete the PACE Program would require Respondent to cease the practice of medicine until a final decision was rendered on an accusation or petition to revoke probation stemming from the failure to successfully complete the clinical program. The Board adopted the Disciplinary Order, which became effective on October 28, 2016.

5. In the Disciplinary Order, Respondent stipulated that at hearing Complainant could establish a factual basis for the charges in a then-pending accusation, that, if proven, the charges constituted cause for discipline, that he gave up his right to contest the allegations, and that if he ever filed a petition for reinstatement the allegations would be deemed true. The accusation alleged that Respondent engaged in excessive prescribing, prescribed controlled substances without an appropriate physical examination or medical indication, prescribed controlled substances to addicts, violated applicable drug laws, engaged in gross negligence, engaged in repeated negligent acts, was incompetent, failed to maintain adequate records, and engaged in unprofessional conduct in connection with his care and treatment of eight patients, and that he suffered a criminal conviction substantially related to the practice of medicine.

6. a. Respondent participated in Phase I of the PACE Program on December 19 and 20, 2017. As part of Phase I, Respondent: underwent physical and mental evaluation, which included a cognitive screening test, the Microcog; completed a history and physical examination on a mock patient; participated in an oral clinical examination; provided a random sample of charts for review; reviewed cases presented through the computerized program PRIMUM; underwent a Transaction Simulated Recall (TSR) interview based on the cases presented in PRIMUM; took multiple choice examinations created by the National Board of Medical Examiners (NBME) and completed other written tests; and participated in an exit interview.

b. PACE physicians described Respondent's performance at the conclusion of Phase I as "varied." (Exh. 7, at p. 9.) Respondent performed very well in the oral competency examination, correctly diagnosed all eight cases in PRIMUM, and demonstrated good medical knowledge and clinical judgment in the TSR interview. However, his sample charts were in need of significant improvement. His performance of the history and physical exam and his write-up of the mock encounter were unsatisfactory. Physical examination revealed diminished hearing, and follow up with an audiologist was recommended. While not suggesting significant cognitive impairment, some deficits were revealed through the Microcog screening test and PACE recommended further mental evaluation. PACE also recommended that Respondent study a specified website to remediate deficiencies in history and physical examination skills.

7. On February 27, 2017, Board Inspector Sandra Borja (Borja) informed Respondent about PACE's recommendation for further study at the cited website. She informed Respondent that the Board will wait until completion of Phase II of the PACE Program before making any judgments about competence.

8. a. Respondent participated in Phase II of the PACE Program on May 1 through May 5, 2017. He spent 38 hours shadowing seven participating internal medicine faculty at University of California, San Diego, clinics. Respondent had the opportunity to participate in the care of patients with a wide variety of conditions and was asked questions about the patients by the treating physicians. The PACE physician overseeing the Phase II assessment, Dr. Cederquist, performed what he called a "Chart Simulated Recall (CSR) Exercise," in which he asked Respondent detailed questions about seven of Respondent's 20 randomly selected patient charts.

b. Respondent was given two additional tests in light of history and physical examination deficiencies identified in Phase I. He repeated the mock history and physical examination, and his performance was satisfactory. Respondent also successfully completed a history and physical examination practicum.

c. In summarizing the comments of the seven physicians Respondent observed during his clinical rounds, Dr. Cederquist concluded that Respondent's performance was "very mixed." (Exh. 7, at p. 12.) Some of the faculty felt Respondent performed in a satisfactory manner, but a few identified significant deficiencies. Of concern was Respondent's ability to reason through the more difficult cases. In administering the CSR, Dr. Cederquist described Respondent's documentation as unsatisfactory and his medical decision-making as substandard.

9. On June 19, 2017, PACE issued its final report, concluding that Respondent had failed the PACE Program and opining that he could not safely practice medicine. In the view of PACE clinicians, despite possessing the requisite knowledge, Respondent was unable to consistently deploy such ability in the actual practice of medicine. PACE evaluators concluded: "We are unsure what is causing [Respondent] to perform in an unsafe manner. There are several possible explanations including a cognitive disorder, sociopathy, and a substance abuse

disorder. However, determining why [Respondent] is not performing safely is beyond the scope of a competence evaluation. To further investigate the causes of [Respondent]'s inability to practice safely, we recommend that he undergo a neuropsychological evaluation (described on pages 2-3 of this report), psychiatric evaluation and toxicology screening." (Exh. 7, at p. 19.)

10. On June 20, 2017, Borja informed Respondent that he had not successfully completed the PACE Program and that the matter was being referred to the Attorney General's Office with a request to pursue disciplinary action against Respondent's license. Borja also informed Respondent of PACE's recommendation for neuropsychological evaluation, psychiatric evaluation, and toxicology screening.

11. On July 11, 2017, Complainant issued a Cease Practice Order, prohibiting Respondent from practicing medicine until a final decision is rendered on an accusation or petition to revoke probation.

12. Respondent underwent the testing and assessment recommended by PACE, and has successfully passed all tests. On June 30 and July 7, 2017, David C. Anderson, Ph.D. (Anderson), conducted a neuropsychological fitness for duty evaluation. Dr. Anderson's testing did not reveal any cognitive impairment. In Dr. Anderson's opinion, Respondent is able to function effectively as a physician and in a manner conducive to public safety. On July 14, 2017, Nathan E. Lavid, M.D., conducted a comprehensive psychiatric evaluation of Respondent and concluded that Respondent's ability to safely practice medicine was not impaired by any psychiatric condition. Respondent was also examined by an audiologist, and hearing aids were not required.

13. Respondent has ceased practicing medicine, as ordered by Complainant. He has continued to study the medical literature to maintain his knowledge, spending about 30 hours per week in this endeavor. He recognizes his record keeping deficiencies and has completed a course to improve in this area. He has a better understanding of what is expected of him to show that he can use his knowledge in the actual treatment of patients.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving, by clear and convincing evidence to a reasonable certainty, that cause exists to discipline Respondent's physician's and surgeon's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1985) 135 Cal.App.3d 853, 856.) This means that the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal –so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.) Complainant has met this burden of proof.

2. Cause exists to revoke probation and to impose the stayed penalty of revocation because Respondent failed to successfully complete the PACE Program as required by Condition number 5 of the Disciplinary Order, by reason of factual finding numbers 4 through 9.

3. The purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476).

4. All evidence presented at the hearing has been considered. Despite failing to successfully complete the PACE Program, Respondent passed many of the program's components. He does not suffer from any physical or mental condition that would impair his ability to practice medicine. His base of knowledge does not seem to be an issue, and Respondent has a better understanding of what is expected of him to show that he can use such knowledge in the actual treatment of patients. Revocation of Respondent's license in these circumstances is punitive and not necessary for the protection of the public. Allowing him another opportunity to demonstrate his clinical skills is appropriate. The order that follows is therefore adequate and warranted for the protection of the public.

ORDER

1. The Petition to Revoke Probation is sustained in part, consistent with this Proposed Decision.

2. Respondent is ordered to remain on probation for the entire five-year period set forth in the Disciplinary Order, plus any time tolled because he has not been practicing medicine, subject to the same terms and conditions set forth in the Disciplinary Order.

DATED: January 22, 2018

DocuSigned by:
A43GB8F75488406...

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 29, 2017
BY [signature] **ANALYST**

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: **Oliver Cheng-Tung Tsai, M.D.** **1433 W. Merced Ave., Ste. 308** **West Covina, CA 91790** **Physician's and Surgeon's Certificate No. A 49033,** Respondent.	Case No. 800-2017-034074 **PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number A 49033 to Oliver Cheng-Tung Tsai, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2018, unless renewed. On September 28, 2016, pursuant to a Stipulated Settlement and Disciplinary Order *In the Matter of the Accusation Against Oliver*

Cheng-Tung Tsai, MD., MBC Case No. 13-2012-222272, Respondent's medical license was revoked with revocation being stayed and Respondent being placed on probation for five (5) years on terms and conditions including, not limited to, completing an approved prescribing practices course, completing an approved medical record keeping course, and passing an approved clinical training program. A true and accurate copy of the disciplinary order is hereto attached, marked Exhibit A.

3. On July 11, 2017, the Board issued a cease practice order based on Respondent's failure to complete, successfully, an approved clinical training program in a timely fashion, as required by Condition No. 6 of his probation. A true and accurate copy of the cease practice order is hereto attached, marked Exhibit B.

JURISDICTION

4. This Petition to Revoke Probation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code provides:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"...

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"...."

CAUSE FOR REVOCATION OF PROBATION

(FAILURE TO PASS PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION PROGRAM)

7. Respondent Oliver Cheng-Tung Tsai, M.D.'s probation is subject to revocation in that he failed to pass an approved clinical training program in a timely fashion. Probationary Condition No. 6 required Respondent, within 60 calendar days from the effective date of the decision—that is, October 28, 2016—to enroll in a clinical training program or educational program equivalent to the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine (PACE Program) and to complete the program within six months of his initial enrollment. Respondent failed to comply with Condition No. 6, as follows:

A. Respondent enrolled in the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine (PACE Program) on October 14, 2016. Accordingly, Condition No. 6 required that he complete the approved clinical education program, successfully, no later than April 13, 2017.

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B. On December 19 and 20, 2016, Respondent presented at the University of California, San Diego, to complete Phase I of the PACE program.

C. On or about and between May 1 and 5, 2017, Respondent presented at the University of California, San Diego, to complete Phase II of the PACE program.

D. Following Respondent's completion of Phase I, a report was prepared which contained the following "Summary and Recommendations:"

> "PACE evaluation and training extend only to professional and clinical knowledge and behavior. All of PACE's findings and recommendations are based on information available to us at the time.
>
> "Overall, [Respondent]'s performance on the Phase I, two-day, assessment was varied. While he performed well overall on the oral clinical exam with Dr. C[], his charts were in need of significant improvement. Poor charting is concerning because it can also reflect poor quality of care and it is difficult to distinguish between the two without a more in-depth evaluation. His performance of the history and physical exam, as well as his write-up of the encounter, was unsatisfactory. He diagnosed all eight cases correctly during the PRIMUM and aside from one case, generally demonstrated very good medical knowledge and clinical judgment during the subsequent TSR. He scored in the 32nd percentile on the internal Medicine Subject Exam. His performance on the Microcog indicated he may need further evaluation; however, we do not have significant concerns about possible cognitive impairment and do not feel that a complete neurological evaluation is warranted at this time. During the physical exam, Dr. P[] found [Respondent]'s hearing to be diminished.
>
> "Based on [Respondent]'s performance during Phase I of the PACE Program physician assessment, we recommend that he study Charlie Goldberg's website at https://meded.ucsd.edu/clinicalmed/ in order to remediate the deficiencies noted in his history and physical examination skills. We also recommend that he follow up with an audiologist for a formal audiogram."

E. Following Respondent's completion of Phase II, a report was prepared which contained the following findings:

1) "[Respondent]'s performance during his Phase II clinical observation was very mixed." . . . in one case, he exhibited very poor judgment in what he said to the patient. Based on the deficiencies identified, I would have concerns about his ability to practice medicine independently in a safe manner."

2) ". . . [Respondent]'s documentation is unsatisfactory, and his medical decision-making appears substandard."

3) "Overall, [Respondent]'s performance during Phase II was unsatisfactory."

4) "[Respondent]'s overall performance on [the] comprehensive, seven-day assessment is consistent with a[] **FAIL – Category 4.**"[1]

F. On or about and during July 2017, Respondent underwent a psychiatric and a neuro-psychiatric evaluation to determine if he was suffering from a cognitive or other impairment interfering with his ability to complete Phases I and II of the PACE Program. No such impairment was found.

G. Respondent violated Probationary Condition No. 6 in that he failed to complete, successfully, an approved clinical education program by April 13, 2017.

//

[1]**Category 4**: Signifies a poor performance that is not compatible with overall physician competency and safe practice. Physicians in this category performed poorly on all [or nearly all] aspects of the assessment. Alternatively, the physician could have a physical or mental health problem that prevents him/her from practicing safely. These physicians are unsafe and, based on the observed performance in the PACE assessment, represent a potential danger to their patients. Some physicians in this category may be capable of remediating their clinical competency to a safe level and some may not. We will provide our recommendations regarding remedial educational activities. The faculty and staff of the UCSD PACE Program do not give an outcome of "Fail" lightly or casually. This assignation reflects major significant deficiencies in clinical competence, and physicians who receive this outcome, if they are deemed to be candidates for remedial education, should think in terms of engaging in a minimum of one fully year of dedicated study and other learning activities requiring an average of 30 to 40 hours per week. Under no circumstances will the UCSD PACE Program allow a physician to participate in a re-assessment less than six months from the time of the completion of the initial assessment.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking the probation that was granted by the Medical Board in Case No. 13-2012-222272 and imposing the disciplinary that was stayed thereby revoking Physician's and Surgeon's Certificate Number A 49033, issued to Oliver Cheng-Tung Tsai, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate Number A 49033, issued to Oliver Cheng-Tung Tsai, M.D.;

3. Revoking, suspending or denying approval of Oliver Cheng-Tung Tsai, M.D.'s authority to supervise physician assistants and advanced practice nurses;

4. Ordering Oliver Cheng-Tung Tsai, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: August 29, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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EXHIBIT A

DECISION

In the Matter of the Accusation Against Oliver Cheung-Tung Tsai, MD.
MBC Case No. 13-2012-222272

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
OLIVER CHENG-TUNG TSAI, M.D.	)	Case No. 13-2012-222272
	)	
Physician's and Surgeon's Certificate No. A 49033	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on October 28, 2016.

IT IS SO ORDERED September 28, 2016.

MEDICAL BOARD OF CALIFORNIA

By: _____
Howard Krauss, M.D., Chair
Panel B

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.

Signature

Title

Date

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
RICHARD D. MARINO
Deputy Attorney General
State Bar No. 90471
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-8644
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **OLIVER CHENG-TUNG TSAI, M.D.** **1433 W. Merced Ave.** **West Covina, CA 91790** **Physician's and Suergeon's No. A 49033,** Respondent.	Case No. 13-2012-222272 OAH No. 2015071369 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Richard D. Marino, Deputy Attorney General.

//

//

2. Respondent Oliver Cheng-Tung Tsai, M.D. (Respondent) is represented in this proceeding by attorney Steven M. Cron. Esq., whose address is: Cron, Israels & Stark, 1541 Ocean Avenue, Suite 200, Santa Monica, California 90401.

3. On or about December 17, 1990, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 49033 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 13-2012-222272, and will expire on November 30, 2016, unless renewed.

JURISDICTION

4. Accusation No. 13-2012-222272 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 12, 2015. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 13-2012-222272 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 13-2012-222272. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

//

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 13-2012-222272, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Suergeon's Certificate No. A49033.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent further agrees that if he ever petitions for early termination of probation, all of the charges and allegations contained in Accusation No. 13-2013-222272 shall be deemed true, correct and fully admitted by Respondent for the purpose of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A49033 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's No. A 49033 issued to Respondent Oliver Cheng-Tung Tsai, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at

Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any Schedule 2 controlled substances as defined by the California Uniform Controlled Substances Act until he has successfully completed the prescribing practices course and submitted a certification of successful completion to the board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision whichever is later, as described in paragraph 2, above.

4. MEDICAL RECORD-KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program

equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation

and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

7. MONITORING – PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants

10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

11. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

13. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

14. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms

and conditions of probation: Obey All Laws; and General Probation Requirements.

15. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Steven M. Cron. Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 07/05/2016 Oliver C. Tsai, M.D.

OLIVER CHENG-TUNG TSAI, M.D.
Respondent

I have read and fully discussed with Respondent Oliver Cheng-Tung Tsai, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7/5/16

STEVEN M. CRON. ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: July 6, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

RICHARD D. MARINO
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 13-2012-222272

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 2 2015
BY L. FINDLAY ANALYST

KAMALA D. HARRIS
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **OLIVER CHENG-TUNG TSAI, M.D.** **1433 W. Merced Ave., Ste. 308** **West Covina, CA 91790** **Physician's and Surgeon's Certificate No. A49033,** Respondent.	Case No. 13-2012-222272 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about December 17, 1990, the Board issued Physician's and Surgeon's Certificate No. A49033 to Oliver Cheng-Tung Tsai, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2016, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California, Department of Consumer Affairs, State of California (Board) under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, in pertinent part, provides:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but

is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"...."

6. Section 2238 of the Code provides:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

7. Section 2241 of the Code provides:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in

subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. Section 2242 of the Code provides:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. Section 2236, subdivision (a), provides:

"The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon, constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred."

10. Section 2266 of the Code provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 725 of the Code, in pertinent part, provides:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

". . ."

12. Health and Safety Code section 11152 provides:

"No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division."

13. Health and Safety Code section 11153, in pertinent part, provides

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a

prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

". . . ."

14. Health and Safety Code section 11190, in pertinent part, provides:

"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

"(1) The name and address of the patient.

"(2) The date.

"(3) The character, including the name and strength, and quantity of controlled substances involved.

"(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

"(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

"(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

"(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

"(C) NDC (National Drug Code) number of the controlled substance dispensed.

"(D) Quantity of the controlled substance dispensed.

"(E) ICD-9 (diagnosis code), if available.

"(F) Number of refills ordered.

"(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

"(H) Date of origin of the prescription.

"(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

"(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

"(d) This section shall become operative on January 1, 2005.

"(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

"(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005."

CONTROLLED SUBSTANCE/DANGEROUS DRUGS

15. The following medications are controlled substances and dangerous drugs within the meaning of the Health and Safety Code and Business and Professions Code:

A. Hydrocodone - is a semi-synthetic opioid synthesized from codeine, one of the opioid alkaloids found in the opium poppy. It is a narcotic analgesic used orally as an antitussive/cough suppressant, but also commonly taken orally for relief of moderate to severe pain.

B. Casodex - Bicalutamide is used to treat prostate cancer that has spread to other areas of the body. It is used in combination with hormone treatment. This medication works by blocking the action of male hormones in the prostate, slowing growth of the tumors.

C. Actos - Pioglitazone is an anti-diabetic drug (thiazolidinedione-type, also called "glitazones") used along with a proper diet and exercise program to control high blood sugar in patients with type 2 diabetes.

D. Oxycodone - This medication is used to help relieve moderate to severe

pain. Oxycodone belongs to a class of drugs known as narcotic (opiate) analgesics. It works in the brain to change how the body feels and responds to pain.

E. Ketoconazole – This medication is used to treat certain serious fungal infections in the body. Ketoconazole belongs to the class of drugs called azole antifungals. It works by stopping the growth of the fungus.

F. Kadian – A form of morphine used to help relieve severe ongoing pain. Morphine belongs to a class of drugs known as narcotic (opiate) analgesics. The higher strengths of this drug (100 milligrams per capsule and higher) should be used only if taking moderate to large amounts of narcotic pain medication. These strengths may cause overdose (even death) if taken by a person who has not been regularly taking narcotic medication.

G. C20 - Cialis - Tadalafil is used to treat male sexual function problems (impotence or erectile dysfunction-ED). In combination with sexual stimulation, tadalafil works by increasing blood flow to the penis to help a man get and keep an erection. Tadalafil is also used to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia-BPH). It helps to relieve symptoms of BPH such as difficulty in beginning the flow of urine, weak stream, and the need to urinate frequently or urgently (including during the middle of the night). Tadalafil is thought to work by relaxing the smooth muscle in the prostate and bladder.

H. Evista - Raloxifene is used to prevent and treat bone loss (osteoporosis) in women after menopause. Raloxifene may also lower the chance of getting a certain type of breast cancer (invasive) in women after menopause. This drug is different from hormones (including estrogens and progestins). It works by acting like estrogen (as a selective estrogen receptor modulator or SERM) in some parts of the body. Raloxifene

helps to preserve bone mass, but it does not affect the breast and uterus like estrogen or relieve symptoms of menopause such as hot flashes.

I. Hydrocodone Liquid - This combination product is used to treat symptoms caused by the common cold, flu, allergies, hay fever, or other breathing illnesses (e.g., sinusitis, bronchitis). Decongestants help relieve stuffy nose symptoms. This product also contains a narcotic cough suppressant (antitussive) that affects a certain part of the brain, reducing the urge to cough. Antihistamines relieve watery eyes, itchy eyes/nose/throat, runny nose, and sneezing.

J. Amoxicillin – This medication is used to treat a wide variety of bacterial infections. This medication is a penicillin-type antibiotic. It works by stopping the growth of bacteria. This antibiotic treats only bacterial infections. It will not work for viral infections (such as common cold, flu). Unnecessary use or misuse of any antibiotic can lead to its decreased effectiveness. Amoxicillin is also used with other medications to treat stomach/intestinal ulcers caused by the bacteria H. pylori and to prevent the ulcers from returning.

K. Sucralfate - This medication is used to treat and prevent ulcers in the intestines. Sucralfate forms a coating over ulcers, protecting the area from further injury. This helps ulcers heal more quickly.

L. Metformin – This medication is used with a proper diet and exercise program and possibly with other medications to control high blood sugar. It is used in patients with type 2 diabetes. Controlling high blood sugar helps prevent kidney damage, blindness, nerve problems, loss of limbs, and sexual function problems. Metformin works by helping to restore the body's proper response to the insulin naturally produced. It also decreases the amount of sugar that the liver makes and that is absorbed by the

stomach/intestines.

M. Carvedilol – This medication is used to treat high blood pressure and heart failure. It is also used after a heart attack to improve the chance of survival if the heart is not pumping well. Lowering high blood pressure helps prevent strokes, heart attacks, and kidney problems. This drug works by blocking the action of certain natural substances in the body, such as epinephrine, on the heart and blood vessels. This effect lowers the heart rate, blood pressure, and strain on the heart. Carvedilol belongs to a class of drugs known as alpha and beta blockers.

N. Levothyroxine – This medication is used to treat an underactive thyroid (hypothyroidism). It replaces or provides more thyroid hormone, which is normally produced by the thyroid gland. Low thyroid hormone levels can occur naturally or when the thyroid gland is injured by radiation/medications or removed by surgery. Having enough thyroid hormone is important for maintaining normal mental and physical activity. In children, having enough thyroid hormone is important for normal mental and physical development. This medication is also used to treat other types of thyroid disorders (such as certain types of goiters, thyroid cancer). This medication should not be used to treat infertility unless it is caused by low thyroid hormone levels.

O. Colchicine - This medication is used to prevent or treat gout attacks (flares). Usually gout symptoms develop suddenly and involve only one or a few joints. The big toe, knee, or ankle joints are most often affected. Gout is caused by too much uric acid in the blood. When uric acid levels in the blood are too high, the uric acid may form hard crystals in the joints. Colchicine works by decreasing swelling and lessening the buildup of uric acid crystals that cause pain in the affected joint(s). This medication is also used to prevent attacks of pain in the abdomen, chest, or joints caused by a certain

inherited disease (Familial Mediterranean fever). It is thought to work by decreasing the body's production of a certain protein (amyloid A) that builds up in people with Familial Mediterranean fever.

P. Haloperidol – This medication is used to treat certain mental/mood disorders (e.g., schizophrenia, schizoaffective disorders). This medicine helps patients think more clearly, feel less nervous, and take part in everyday life. It can also help prevent suicide in people who are likely to harm themselves. It also reduces aggression and the desire to hurt others. It can decrease negative thoughts and hallucinations. Haloperidol can also be used to treat uncontrolled movements and outbursts of words/sounds related to Tourette's disorder. Haloperidol is also used for severe behavior problems in hyperactive children when other treatments or medications have not worked. Haloperidol is a psychiatric medication (antipsychotic-type) that works by helping to restore the balance of certain natural substances in the brain (neurotransmitters).

Q. Clonazepam – This medication is used to prevent and control seizures. This medication is known as an anticonvulsant or antiepileptic drug. It is also used to treat panic attacks. Clonazepam works by calming the brain and nerves. It belongs to a class of drugs called benzodiazepines.

R. Tramadol – This medication is used to help relieve moderate to moderately severe pain. Tramadol is similar to narcotic analgesics. It works in the brain to change how the body responds to pain.

S. Dicyclomine – This medication is used to treat a certain type of intestinal problem called irritable bowel syndrome. It helps to reduce the symptoms of stomach and intestinal cramping. This medication works by slowing the natural movements of the stomach and by relaxing the muscles in the stomach and intestines. Dicyclomine belongs

to a class of drugs known as anticholinergics/antispasmodics. This medication must not be used in children younger than 6 months old because of the risk of serious side effects.

T. Amlodipine – This medication is used with or without other medications to treat high blood pressure. Lowering high blood pressure helps prevent strokes, heart attacks, and kidney problems. Amlodipine belongs to a class of drugs known as calcium channel blockers. It works by relaxing blood vessels so blood can flow more easily. Amlodipine is also used to prevent certain types of chest pain (angina). It may help to increase the ability to exercise and decrease the frequency of angina attacks.

U. Levofloxacin – This medication is used to treat a wide variety of bacterial infections. Levofloxacin belongs to a class of drugs called quinolone antibiotics. It works by stopping the growth of bacteria. This medication will not work for viral infections (such as common cold, flu).

V. Glimepiride – This medication is used with a proper diet and exercise program to control high blood sugar in people with type 2 diabetes. It may also be used with other diabetes medications. Controlling high blood sugar helps prevent kidney damage, blindness, nerve problems, loss of limbs, and sexual function problems. Proper control of diabetes may also lessen the risk of a heart attack or stroke. Glimepiride belongs to the class of drugs known as sulfonylureas. It lowers blood sugar by causing the release of the body's natural insulin.

W. Acetaminophen with Codeine - This medication is used to relieve mild to moderate pain. This product is a combination of acetaminophen and the narcotic drug codeine. Codeine acts on certain centers in the brain to reduce pain. This medication may also be used to suppress a cough.

X. Meclizine – This medication is an antihistamine that is used to prevent and

treat nausea, vomiting, and dizziness caused by motion sickness. It may also be used to reduce dizziness and loss of balance (vertigo) caused by inner ear problems.

Y. Prochlorperazine – This medication is used to treat severe nausea and vomiting from certain causes (for example, after surgery or cancer treatment). Prochlorperazine belongs to a class of drugs known as phenothiazines. This medication is not recommended for use in children younger than 2 years or in children going through surgery.

Z. Ciprofloxacin – This medication is used to treat a variety of bacterial infections. Ciprofloxacin belongs to a class of drugs called quinolone antibiotics. It works by stopping the growth of bacteria. This antibiotic treats only bacterial infections. It will not work for virus infections (such as common cold, flu). Unnecessary use or overuse of any antibiotic can lead to its decreased effectiveness.

AA. Dexamethasone – This medication is used to treat conditions such as arthritis, blood/hormone/immune system disorders, allergic reactions, certain skin and eye conditions, breathing problems, certain bowel disorders, and certain cancers. It is also used as a test for an adrenal gland disorder (Cushing's syndrome). This medication is a corticosteroid hormone (glucocorticoid). It decreases the body's natural defensive response and reduces symptoms such as swelling and allergic-type reactions.

BB. Tricor – Fenofibrate is used along with a proper diet to help lower "bad" cholesterol and fats (such as LDL, triglycerides) and raise "good" cholesterol (HDL) in the blood. It belongs to a group of drugs known as "fibrates." It works by increasing the natural substance (enzyme) that breaks down fats in the blood. Lowering triglycerides in people with very high triglyceride blood levels may decrease the risk of pancreas disease (pancreatitis).

CC. Compazine – Prochlorperazine is an anti-psychotic medicine in a group of drugs called phenothiazines. It works by changing the actions of chemicals in the brain. Prochlorperazine oral (taken by mouth) is used to treat psychotic disorders such as schizophrenia. It is also used to treat anxiety, and to control severe nausea and vomiting.

DD. Diazepam – This medication belongs to a class of drugs called benzodiazepines which act on the brain and nerves (central nervous system) to produce a calming effect. It is used to treat anxiety, acute alcohol withdrawal, and seizures. It is also used to relieve muscle spasms and to provide sedation before medical procedures.

EE. Lisinopril – This medication is used to treat high blood pressure (hypertension). Lowering high blood pressure helps prevent strokes, heart attacks, and kidney problems. It is also used to treat heart failure and to improve survival after a heart attack. Lisinopril is an ACE inhibitor and works by relaxing blood vessels so that blood can flow more easily.

FF. Diltiazem – This medication is used to prevent chest pain (angina). Diltiazem is called a calcium channel blocker. It works by relaxing blood vessels in the body and heart and lowers the heart rate. Blood can flow more easily and the heart works less hard to pump blood.

GG. Butalbital-Acetaminophen-Caffeine – This combination medication is used to treat tension headaches. Acetaminophen helps to decrease the pain from the headache. Caffeine helps increase the effects of acetaminophen. Butalbital is a sedative that helps to decrease anxiety and cause sleepiness and relaxation.

HH. Triamterene/hydrochlorothiazide – This medication is used for treating fluid retention (edema) and high blood pressure in certain patients. Triamterene/hydrochlorothiazide is a diuretic (water pill), and is a combination of a

potassium-sparing diuretic (triamterene) and a thiazide diuretic (hydrochlorothiazide). It works by making the kidneys eliminate sodium (salt) and water from the body, which helps to lower blood pressure. The triamterene component helps minimize potassium loss.

II. Zyprexa – Olanzapine is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder). It may also be used in combination with other medication to treat depression. Olanzapine belongs to a class of drugs called atypical antipsychotics. It works by helping to restore the balance of certain natural substances in the brain.

JJ. Metronidazole – This medication is used to treat a variety of infections. It belongs to a class of antibiotics known as nitroimidazoles. It works by stopping the growth of bacteria and protozoa. This antibiotic only treats bacterial and protozoal infections. It will not work for viral infections (e.g., common cold, flu). Unnecessary use or overuse of any antibiotic can lead to its decreased effectiveness. Metronidazole can also be used in combination with anti-ulcer medications to treat certain types of stomach ulcers.

KK. Temazepam (Restoril) – This medication is used to treat sleep problems (insomnia). Temazepam belongs to a class of drugs called sedative-hypnotics.

LL. Viagra – Sildenafil is used to treat male sexual function problems (impotence or erectile dysfunction-ED). In combination with sexual stimulation, sildenafil works by increasing blood flow to the penis to help a man get and keep an erection.

MM. Diphenoxylate-Atropine - This medication is used to treat diarrhea. It helps to decrease the number and frequency of bowel movements. It works by slowing

the movement of the intestines. Diphenoxylate is similar to narcotic pain relievers, but it acts mainly to slow the movement of the intestines. Atropine belongs to a class of drugs known as anticholinergics, which help to dry up body fluids and also slow gut movement.

NN. Xanax (Alprazolam): a Schedule III controlled substance used to treat anxiety.

OO. Lortab - This combination medication is used to relieve moderate to severe pain. It contains a narcotic pain reliever (hydrocodone) and a non-narcotic pain reliever (acetaminophen). Hydrocodone works in the brain to change how the body feels and responds to pain. Acetaminophen can also reduce a fever.

PP. Ambien - Zolpidem is used to treat sleep problems (insomnia) in adults. Zolpidem belongs to a class of drugs called sedative-hypnotics. It acts on the brain to produce a calming effect. This medication is usually limited to short treatment periods of 1 to 2 weeks or less.

QQ. Elavil – This medication is used to treat mental/mood problems such as depression. It may help improve mood and feelings of well-being, relieve anxiety and tension, help with sleep, and increase energy. This medication belongs to a class of medications called tricyclic antidepressants. It works by affecting the balance of certain natural chemicals (neurotransmitters such as serotonin) in the brain.

RR. Naprosyn – This medication is used to relieve pain from various conditions such as headaches, muscle aches, tendonitis, dental pain, and menstrual cramps. It also reduces pain, swelling, and joint stiffness caused by arthritis, bursitis, and gout attacks. This medication is known as a nonsteroidal anti-inflammatory drug (NSAID). It works by blocking the body's production of certain natural substances that cause inflammation.

INTRODUCTION

16. According to Respondent, in describing his practice, he states he is in solo practice with no physician assistants or nurse practitioners. He reported that he has two office employees and a third person who serves as an office manager. In addition, he stated that he does hospital rounds when the patients are in the hospital. The patients then follow up with him in the office after discharge. Respondent sees between 20 and 25 Medicare and HMO patients daily. According to Respondent, he no longer sees Medi-Cal patients; and, as a result, his practice has slowed.

17. Respondent is board certified in internal medicine but he sees patients with a wide variety of medical conditions.

18. According to Respondent, he feels comfortable with prescribing pain medications and has only infrequently dropped a patient for drug seeking behavior. He requires patients to sign a pain contract. He does not have patients do urine drug screens or random screens due to cost of the tests.

19. According to Respondent, he screens patients for red flags for overuse of opioids. He tries to provide alternative medications or send them to a pain management physician. He has referred patients to pain management "many" times - maybe 2-3% of his patients. According to Respondent, 15 to 20% of his practice comprise of pain management patients.

20. According to Respondent, the pain contract discusses early refills, but does not require his patient to go to one pharmacy.

21. Respondent is aware of CURES but does not utilize this.

22. Respondent is aware that some of his patients obtain medications for street sale.

23. Respondent works Monday through Saturday, from 7:30 a.m. until 5 p.m.

24. According to Respondent, if he dismisses a patient, he does so by telephone; and, that if a patient comes in "high" he would "scold" the patient, examine the patient, and would

discuss this (their altered state) with them. According to Respondent, he would not dismiss the patient immediately.

25. According to Respondent, if a patient asks for an early refill, that patient is dismissed. According to Respondent, he does not refer them to another physician and does not give them a list of alternative physicians.

26. According to Respondent, if a new patient comes in for a Vicodin refill, he tries to get old records. According to Respondent, he may prescribe 15 days of medication and attempts to retrieve the patient's records.

27. According to Respondent, if he feels the patient needs tests, such as liver tests, he orders them.

28. According to Respondent, he has given small amounts of pain medication to patients with a history of drug or alcohol abuse.

29. According to Respondent, his patients complete an intake form or questionnaire. However, Respondent admits that not all of his patients complete a form with a pain scale. Instead, according to Respondent, he verbally discusses with each patient how well his/her pain is controlled.

30. According to Respondent, he has less than five or ten patients that have an addiction problem.

31. According to Respondent, when a patient comes in for pain treatment, the patient must sign a pain contract.

32. Respondent does not co-manage patients with a pain management specialist.

33. According to Respondent, when a patient presents with pain and asks for Vicodin and Xanax, he would get more information regarding the injury and specific symptoms, such as back pain. He would ask for the name and telephone number of the previous treating physician

and attempt to call the individual if possible. He would ask if the patient had any x-rays and try to get more information about the past injury. Respondent, next, would do an exam of the back, looking at the back, and asking exactly where the pain was. He would touch that area to see if it was painful and asked the patient to do some maneuvers. He would ask the patient if the pain went down the legs, had any tingling sensations, or any problems with urination or bowel movements. He would ask if there were any side effects from medications, such as constipation problems or drowsiness. At the end of the exam he stated he would prescribe some medication—sometimes Vicodin is the medication usually requested; sometimes Naprosyn or meloxicam.

34. When prescribing Vicodin, Respondent begins with a 15 day supply. He asks the patient to get an x-ray and orders laboratory tests. If the patient came back in 15 days but had not done the x-ray testing because he did not have money, Respondent would insist on them getting the x-ray because it is not expensive. Respondent, however, would prescribe another 15 day course of Vicodin in order for the patient to obtain the x-ray. If the patient continued to refuse to get the x-ray, Respondent would dismiss the patient.

35. Respondent limits the amount of Vicodin prescribed to 4 times a day maximum.

36. According to Respondent, if a patient presented with sleep issues, he would prescribe Elavil, not Ambien. Elavil is a tricyclic antidepressant and would help relax muscles. Respondent was asked if a patient stated that he was stressed out and yelling at his wife, would Respondent prescribe Xanax. Respondent replied that he would not and that, if anything, he would paroxetine, fluoxetine or Celexa. He added that he has some medications in the office and he can give the patient Cymbalta which also helps.

37. According to Respondent, he does not see new patients that only pay cash as these patients are often dishonest.

38. According to Respondent, the only medications he keeps in his office are those

that belonged to now deceased patients; that, on occasion, he has given these medications to other patients in an emergency situation. In addition, Respondent admitted that he does not keep a log of these pills given to the patient and does not put this information in the patient's chart.

39. According to Respondent, he has given patients 10 pills, including Vicodin, to cover them over the weekend.

40. Respondent admitted that he had given Patient M.G. some Vicodin which had been returned to his office.

41. Respondent says he charges $100 for an office visit. He said he never told patients to bring him their used medications or medications of those who had passed away, however, they knew to bring them into the office. He says that they call and ask if they can bring him the medications; he says that they may do so.

42. One patient for whom medications were brought in recently was D.P. Respondent thought there was one medication that is a controlled substance, possibly Vicodin.

43. According to Respondent, he also took returned medication to his home to store. Respondent says he will not prescribe controlled substances to his family.

44. During a search warrant executed by members of law enforcement at Respondent's office, the following prescriptions were observed:

Name on bottle	Drug	Quantity prescribed	Quantity in bottle
M.P.	Hydrocodone	120	31
D.S.	Casodex	30	0
J.R.	Actos	90	88
Name ripped off	oxycodone	60	33
A.H.	Ketoconazole	30	28
M.G.	Kadian	60	6
No name	Oxycodone	Unknown	1
No name	"C20" yellow pills	Unknown	5
No patient name	Evista	30	0
C.C.	Hydrocodone (liquid)	15 mL	2 oz
J.P.	Hydrocodone	120	90
C.C.	Amoxicillin	40	15
R.G.	Sucralfate	120	105
A.P.	Hydrocodone	120	95
R.M.	Metformin	60	17 ½

R.G.	Carvedilol	60	47
L.C.	Levothyroxine	90	88
D.P.	Colchicine	80	16
L.G.	Levothyrox	90	90
R.G.	carvedilol	120	161 ½
L.C.	Haloperodal	60	38
T.T.	Calcium	180	121
R.G.	Clonazepam	120	116
H.P.	Tramadol	180	124
L.C.	Dicyclomine	120	97
R.G.	Amlodipine	30	7
A.J.	Tramadol	200	162
L.C.	Levofloxacin	10	6
R.G.	Levothyroxine	30	61
B.R.	Glimepiride	30	1
C.C.	Acetaminophen with Codeine	120	54
R.G.	Meclizine	20	29
R.G.	Carvedilol	60	35
R.G.	Clonazepam	90	69
L.C.	Prochlorperazine	60	44
J.V.	Ciprofloxcicin	14	4
R.M.	Dexamethasone	20	14
C.R.	Tricor	30	5
No name	Compazine	Unknown	15
B.B.	Tramadol	40	23
A.P.	Diazepam	40	2
L.W.	Lisinopril	30	30
M.L.	Diltiazem	30	26
C.C.	Butalb-apap-caff	120	79
R.G.	Clonazepam	120	155
A.Y.	Triamt/hctz	180	145
R.G.	Clonazepam	120	122
R.G.	Clonazepam	120	189
R.G.	Clonazepam	90	70
R.G.	Zyprexa	30	49
M.G.	Metronidazol	45	6
R.G.	Meclizine	120	96
R.G.	Temazepam	30	7
L.M.	Viagra	3	3
L.G.	Levothyrox	90	90
J.V.	Diphenoxylate/atropine	60	29
No label	Yellow "C5" pills	90	89
R.G.	Haloperidol	30	68

APPLICABLE STANDARDS OF CARE

45. Sample medication provided to patients in specific instances. The medications must be obtained from a reliable legal source (e.g. pharmaceutical representative, drug manufacturer, etc.) When providing them directly to the patient, a log of the medication given

must be kept and maintained. Documentation of the specifics must also be entered in the patient's chart.

46. Medications returned by patients must be disposed of in an appropriate manner. This must be in a manner that would not be available for others to obtain, or a risk to the environment. At no time is it permissible to give returned medications to another patient by the physician for any reason. Both US Federal Drug Agency and California regulations forbid the donation of medications that have been in the possession of any individual member of the public (California Senate Bill 1329). The risk of drug tampering is a potential problem among others. Any return of unopened medications in tamper-evident packaging may be donated based on financial need, but only if meeting strict guidelines. These include record keeping and documentation in the patient's chart.

47. Physicians may discharge a patient from their practice for cause for a number of reasons. These may include treatment non-compliance, nonpayment of bills, verbal abuse or violent behavior, failure to follow-up, repeatedly cancelling appointments, among others. When a physician discharges or terminates a patient from the practice, appropriate procedures must be followed. These include:

- Written notice of termination
- Reason for termination (usually included)
- Effective date - usually 30 days to allow the patient to find another provider (this may be shortened if the patient has terminated the relationship, or the patient or family member has exhibited threatening behavior or threatened the provider)
- Interim care provisions - Notifying the patient whom to see in the interim
- Offering a copy of the medical records
- Explaining that medications will only be provided until the effective date

48. Standard of care dictates that a good faith exam (including sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical exam, testing, etc.) is necessary when seeing a patient and as a part of making a treatment plan. This history and exam must also be documented in the medical records. All of the components listed may not be needed for every presenting problem or visit – many diagnoses may be made without laboratory or imaging testing, but these must be considered. Performing the necessary elements and medical record documentation of these is vital.[1]

49. Standard of practice dictates that documentation must be sufficient for the presenting problems or complaints, including sufficient components of history, review of symptoms, physical exam, etc. All of the components listed may not be needed for every presenting problem and visit – many diagnoses may be made without laboratory or imaging testing, but these must be considered. The documentation of the history must be sufficient to determine the diagnosis, or most probable diagnosis, or whether the condition is stable or unstable, giving guidance to the exam, additional tests, etc. The documentation must document

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[1] An exam appropriate for the presenting complaint, or chronic diagnosis, is vital and is standard of care. For chronic problems, repeated exams are vital to better identify changes in condition, success or failure of treatment, etc. On occasion an examination of the patient may not be necessary and the patient may be treated presumptively; however, this must be clearly documented.

For patients taking controlled substances, periodic updates of the history and examination are vital. If the patient is stable or under good control, the history and exam must be done at least every six months. If the patient is not stable, or not well controlled, more frequent updates need to be done. Pain requiring an advancement of dosing or change in therapy needs an updated history and exam.

The written documentation must include and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues.

The history obtained when evaluating chronic back (or other chronic) problems must be sufficient to determine the diagnosis, or most probable diagnosis, giving guidance to the needed exam, additional tests, etc. Documenting potentially significant symptoms or signs that could have much more serious etiologies is important. For back pain this includes radiation of pain, pain severity, neurological symptoms, fever or weight loss, incontinence, saddle anesthesia, etc. to name a few. The exam must be sufficient to rule out more serious etiologies. For back pain this should include: visual observation of the back, palpation of the back for tenderness or other abnormalities, range of motion testing, straight leg raising testing, and neurological testing (sensory, motor, deep tendon reflexes).

and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues. The documentation must accurately reflect what actually happened and must not document details that did not happen in the visit.

50. Standard of care dictates that when prescribing medications, informing the patient of potential risks and benefits is required. Studies have shown that prescribing opioids Morphine Equivalent Dosing (MED) over 100 – 125 mg daily results in a greater than 8 fold increase in overdose risk and an annual overdose risk of nearly 2%, and an increased risk of death. Patients who necessitate dosing in excess of 120 mg MED require informed consent including explaining potential risks (including death); close monitoring; subspecialty consultation; urine drug test monitoring, and seeking alternative treatment regimens that reduce the risk to the patient.

51. Standard of care dictates that when dealing with chronic pain, a thorough history and examination is necessary to ensure that the pain is appropriately managed. In addition, when large amounts of pain medications are prescribed, frequent monitoring is needed. This includes exploring possible side effects, possible red flags for addiction, etc. An exam appropriate for the presenting complaint, or chronic diagnosis, is vital and is standard of care. For chronic problems, repeated exams are vital to better identify changes in condition, success or failure of treatment, etc. On occasion, an examination of the patient may not be necessary and the patient may be treated presumptively; however, this must be clearly documented. When it becomes apparent that one is dealing with chronic pain, especially when necessitating long-term opioid treatment, an expanded history is vital. Obtaining more detailed historical information is vital, including past medical records, information regarding prior laboratory or imaging studies, and past consult details. Managing chronic pain necessitates a different strategy than solely managing the symptoms with chronic opioid medications, even when the symptoms continue. Additional evaluation is warranted depending on the nature of the pain. Neck or back imaging is vital if the

problem is chronic and/or severe. Alternative modalities, both using medication and other treatments are vital in managing chronic pain. When appropriate other medications that can be utilized are non-steroidal anti-inflammatory medications and tricyclic antidepressants (which help some types of chronic pain). Other non-pharmaceutical modalities that may be helpful include physical therapy, acupuncture, chiropractic care, and others. Chronic pain patients on controlled substance medications need periodic review by subspecialists, especially if requiring high doses of opioids and/or if their pain is not well controlled. This is to confirm that the diagnosis and that management are appropriate.

52. The standard of care when seeing a patient with chronic back pain requires obtaining a history sufficient to determine the diagnosis, or most probable diagnosis, giving guidance to the needed exam, additional tests, etc. Documenting potentially significant symptoms or signs that could have much more serious etiologies is important. For back pain this includes radiation of pain, pain severity, neurological symptoms, fever or weight loss, incontinence, saddle anesthesia, etc. The exam must be sufficient to rule out more serious etiologies. For back pain this should include: visual observation of the back, palpation of the back for tenderness or other abnormalities, range of motion testing, straight leg raising testing, and neurological testing (sensory, motor, deep tendon reflexes).

53. Chronic back (or other) pain that is not improving, especially when controlled medications are used long-term, requires additional evaluation to attempt to arrive at a specific diagnosis if one can be identified. Further evaluation may include imaging (such as x-ray, CT or MRI), consideration of testing for non-muscular causes of back (or other) pain (abdominal etiologies, infectious, malignancy, etc.). Management strategies for chronic back pain must include a management plan, use of medication and non-medication modalities (e.g. physical therapy, exercises, heat, acupuncture, chiropractic care, etc.). Patients not improving should

warrant the consideration of evaluation by a subspecialist – such as a pain management specialist, orthopedist, or physical medicine and rehabilitation specialist (and enforcement that this occurs as a condition of continued prescribing). For other chronic pain such as headaches, a neurologist or headache specialist evaluation may be indicated when not improving.

54. The standard of care when seeing a patient with congestive heart failure (CHF) is to perform and document a complete related history, past medical history, family history, and physical exam. These are vital to better arrive at an etiology of the CHF (systolic vs diastolic) and to develop an appropriate short-term and long-term management plan as indicated. The following do not have to occur at each visit, but when the patient is not stable or worsens, treatment must be advanced as needed.

In evaluating CHF, the history needs to include questions such as shortness of breath, edema, orthopnea, paroxysmal nocturnal dyspnea, palpitations, right upper quadrant abdominal discomfort due to acute hepatic congestion, and chest pain. It is vital to inquire as to symptoms and history related to CAD, hypertension, hyperthyroidism, smoking and alcohol use, among other possible etiologies. These both help with developing a differential diagnosis and deciding on the severity of the CHF. Exploring the past medical history is vital, including past history of cardiac or cardiac related disease, history of heart murmurs, history of rheumatic heart disease, hyperlipidemia, thyroid disease, and others that could result in CHF. The family history of cardiac and cardiac-related disease is important. Vital signs need to be obtained, including temperature, heart rate (pulse), blood pressure, respiratory rate, and body weight. The physical exam should be complete, especially including neck exam for jugular venous distension (JVD), cardiac exam including evaluating for heart murmurs and an S3 gallop, lung exam looking for signs of pulmonary congestion, abdominal exam including looking for hepatojugular reflux, and extremity exam for pulses and edema.

Further evaluation needed is a chest x-ray and electrocardiogram (EKG). An echocardiogram is indicated to evaluate many aspects about the heart, including ventricular size and function, valvular function and disorders, wall motion and ejection fraction, cardiomyopathies, and other abnormalities of the heart.

Bloods tests should include a complete blood count (CBC) as anemia can exacerbate heart failure; electrolytes, thyroid (TSH) test, and creatinine as a baseline and to follow when using diuretics; and liver function tests which may be affected by hepatic congestion.

CHF management is based on the severity of the diagnosis at the time, as well as the specific etiology when this can be determined. Management generally should include the use of a diuretic, generally by using of furosemide – a potent diuretic; an angiotensin converting enzyme (ACE) -inhibitor or angiotensin receptor blocker (ARB). A beta-blocker medication (such as carvedilol) is often utilized. Further patient instruction is vital for patients with CHF, including fluid restriction, low sodium diet, cigarette cessation if one is a smoker, and close monitoring. Treatable causes of the CHF should be treated if identified. These may include valvular heart disease, ischemic heart disease, hypertension, hyperthyroidism, substance abuse, and others.

55. Providers must pay attention to the patient and conditions regardless of the purpose of their visit. When the blood pressure is abnormal (140/90 or higher), the provider must discuss this with the patient. Failure to attempt to control the blood pressure puts the patient at higher risk for serious complications from HTN (assuming that the diagnosis is confirmed) including stoke, myocardial infarction (heart attack), kidney disease, etc. Rechecking the blood pressure at the same visits, and on additional visits if still high, is vital in managing this potential significant medical problem. Aggressive treatment regimens are needed to reduce the blood pressure, as well as emphasis on medication compliance. Additional modalities to decrease the blood pressure include stopping smoking, low sodium diet, exercise, stopping caffeine if any, etc.

For patients with very high blood pressure, additional history and examination are needed. In addition, often additional laboratory or other testing may be needed to rule out secondary causes of the hypertension.

56. The standard of care for a patient with migraine headaches is to get a sufficient history to verify the diagnosis. Migraine headaches are episodic, in which key symptoms include a severe headache, usually associated with nausea, with or without light or sound sensitivity. Migraines may or may not include a prodrome 24-48 hours prior to the headache (e.g. euphoria, depression, irritability, neck stiffness, etc.) Some experience an aura – which includes one or more focal neurological symptoms (e.g. visual, sensory, or other).

PATIENTS

57. On or about and during 2013, Respondent prescribed controlled substances to M.G., C.B., A.C., J.M., C.M.B., P.P., T.M., A.G., and others.[2]

PATIENT M.G.

A. According to Respondent, M.G. is in her 60's; has many medical issues; and, has been taking pain medication for a long time. She has had back surgeries, heart problems, hypertension, and migraine headaches. She was seen at the Scripps Clinic but has a hard time finding doctors to treat her and still comes into his office. He thought that she had been his patient for approximately 13-14 years. He had concerns regarding prescribing medications to her. He stated that she complained about migraine headaches and that he had referred her to a neurologist, pain management physicians, and orthopedic doctors. He said she never exercised. He said that she needs someone who can really help her manage her blood pressure problems and arthritis problems. Respondent said

[2] In order to protect their rights of privacy, all patient references are by initials only. The true names of the patients are known to Respondent and, in any event, will be provided to him upon his timely request for discovery.

that she would want to try different medicines from the same category. She went through withdrawal and that he no longer prescribes pain medications to her. He said that she is doing well and that he cut back her general medications as well. He was happy with his management of this patient. However, Respondent saw this patient many times in which her blood pressure was elevated, and many times very highly elevated. There was little or no attention paid to the hypertension. In a patient with CHF, controlling the blood pressure is vital; it is likely to have contributed to her myocardial infarction in 2013.

B. During the 11 month period between March 3, 2011 and February 24, 2012, Patient M.G. received an average of 14 narcotic medications per day from Respondent. The medications were codeine, morphine, and hydrocodone.

C. Respondent saw Patient M.G. on approximately 80 occasions. Respondent failed to take an adequate history of her pain, failed to obtain a sufficient past medical history (past records, imaging, consultant information, past treatments, etc.) Respondent failed to obtain further evaluation of her pain (back, neck, migraine, etc.), such as imaging, physical therapy, pain management, physical medicine, or neurology consultation information. Urine drug screens and obtaining CURES reports were not done. Laboratory monitoring (such as liver function serology testing and urine drug testing) was not performed. Imaging (head, back, etc.) was not done. Other than the initial questionnaire (on which patients are often not truthful regarding substance abuse), Respondent failed to inquire regarding addiction or substance abuse history. He prescribed multiple opioids for her back, headache, etc. for long period of time, all of which are quite addicting. In spite of ongoing pain that was often not well controlled, though no pain scales or functional objective evaluations were used, Respondent failed to obtain further testing or consultative assistance as indicated. Respondent did not develop

a treatment plan for the patient's migraine complaints.

D. Respondent treated this patient with dosages of opioids in excess of 120 mg MED for a prolonged period of time and did not discuss the benefits and risks of this treatment with the patient. Respondent did not explore alternative therapies or failed to document that he had done so.

E. Respondent did not utilize CURES reports in the treatment of Patient M.G.

F. Respondent did not perform any blood or urine tests.

G. Respondent failed to evaluate Patient M.G.'s congestive heart failure.

H. Respondent saw Patient M.G. on January 3, 2012, for hematemesis (vomiting blood). Respondent's history for that visit was limited. Respondent recorded that he performed an abdominal examination with normal results. A stat Hemoglobin was indicated but was not performed.

PATIENT C.B.

I. According to Respondent, C.B. is a Medi-Cal patient and he had not seen her for a long time. "She is a very unfortunate patient." She has severe rheumatoid arthritis, she is crippled, and her son is not much help. He prescribed high-dose or large quantities of medications to her but will not prescribe morphine as she is no longer his patient. Respondent said her rheumatologist called and asked if he, Respondent, would prescribe morphine for Patient C.B. He agreed to write the prescription for morphine one time and was comfortable with doing so.

J. According to his records, Respondent saw this patient many times. However, there are only two progress notes in the patient file. On the other hand, CURES reflects Respondent prescribed controlled substances and other dangerous drugs over a lengthy time period. During the 10 month period between March 4, 2011 and January 14,

2012, she received an average of 11 narcotics medications per day. Respondent failed to discuss the added risks with the patient, including additional risks of overdose and death. There was no evidence of laboratory testing including liver function testing, urine drug testing, or a check with CURES report.

PATIENT A.C.

K. According to Respondent, A.C. is a Medi-Cal patient that he has not seen for a long time. He said that she has a lot of pain issues as well as other medical conditions, including a lot of anxiety and depression issues. He felt that the amount of pain medication was appropriate for her , that he would not let her come back early for refills, and that he was very strict to instruct her not to exceed the prescribed amounts of medication. He was comfortable with the treatment that he gave her.

L. Respondent performed an abdominal examination on July 13, 2013, but did not evaluate the results or document that he had done so.

PATIENT J.M.

M. According to Respondent, J.M. is his patient. J.M. is in his late 60's; he has chronic hepatitis C. He had a liver transplant at UCLA and had a tremendous amount of pain following the surgery. According to Respondent, he had to "argue" with J.M. many times regarding the pain treatment because he wanted more pain medication. J.M. continues to be a patient and is currently on methadone treatment which appears to control his pain.

N. The CURES report revealed that Respondent provided prolonged periods of treatment to J.M. wherein he prescribed multiple narcotic pills, including methadone. The most recent was between February 2, 2013, and December 27, 2013, a 10 month period, where Patient J.M. was taking over 9 narcotic pills per day.

O. Respondent treated Patient J. M. for chronic pain for over three years. His treatment of chronic pain consisted of opioids, often using two opioids--methadone and Norco—at the same time. Respondent did not identify specific etiologies of the patient's pain via history, past medical history, exam, imaging or consultation or, in that alternative, did not document that he had done so.

P. Respondent did not contact Patient J.M.'s prior treating physicians or, in the alternative, failed to document that he had done so.

PATIENT C.M.B.

Q. Patient C.M.B. was not a patient but a Medical Board of California investigator posing as a patient during multiple undercover operations.[3] The patient's initial visit was on April 18, 2013. (When the patient telephoned Respondent's office on April 15, 2013, she was told that Respondent was not taking new patients. The following day, the patient called and said that she was a former patient. An appointment was scheduled.)

R. On April 18, 2013, the patient, accompanied by Medical Board of California Investigator L.B., was seen by Respondent. She initially spoke Spanish when greeted by the receptionist and was asked if she had an appointment. When she stated that she did, she was given paperwork to complete and she paid $100 for the office visit and received a receipt for the payment.

S. After the receptionist took her blood pressure and weight, Patient C.M.B.

[3] Undercover investigations were carried out on multiple occasions, including April 18, 2013; May 13, 2013; July 3, 2013; September 10, 2013; and December 18, 2013. The undercover reports suggest that Respondent would prescribe medication as requested by the undercover agent without any physical examination or without a thorough history and physical examination. Respondent told the undercover investigator that she should not take more than four narcotic pills per day. Respondent's CURES report indicates that most patients would receive double or triple this amount of narcotics.

was escorted to an exam room. She was asked about her family history (diabetes) and surgeries (C-section), and her menstrual periods. She was asked where she lived, whether she was employed (she replied she was just training), whether she smoked, whether she drank, and whether she had any allergies.

T. Patient C.M.B. said she was there for back pain

U. Patent C.M.B. told Respondent that she had been seen about one year prior but that he was busy at the time. She said she had a car accident about two years prior and got some Vicodin. "It just helps me." she told him

V. When asked about her back problems, she said she had a car accident and that her back hurt and mentioned her neck as well. She said she had other problems and wanted something to help her. When asked about her other problems, she said there were many problems and that she wanted something in order to relax a bit. She added that there were things going on with her daughter and asked if her daughter could get something, too.

W. Respondent asked what kind of work she did. Patient C.M.B. replied that she did housecleaning. She also said her daughter was very difficult. She said she had used Vicodin ES and that she took them every 4-6 hours. Respondent relied, "that's a lot".

X. Respondent asked the patient who the doctors were who were prescribing the medication and she said that she had just taken it before without providing any specifics. He asked whether they figured out what caused the pain in her neck and back. She said that the pain started with the accident but that she feels better. Again, she said that she did not have the pain at the time but it [medication] helped her relieve the stress as well. The medications helped her relax and not worry about her problems as much.

Y. Respondent asked the patient if she had trouble sleeping. Patient said that she does not sleep well since leaving her husband.

Z. Respondent tested her lungs and examined her back.

AA. Respondent asked if she had considered taking antidepressants. Patient C.M.B. said that she felt that Vicodin had worked better in the past and that she did not want an antidepressant.

BB. Respondent asked if she drank alcohol and she said that she did a couple of times per week - mostly wine, wine coolers, or beer.

CC. Respondent asked how she keeps her back in shape, whether she exercises. She stated that sometimes she does floor exercises. He stated the exercises do not have to be done on the floor. The exercise could be done while standing up.

DD. Respondent prescribed Vicodin, #120.

EE. Respondent's chart for Patient C.M.B., for April 18, 2013, showed no recorded past medical history, family history, or immunization status. The chart did document a physical examination.

FF. Respondent failed to obtain information regarding the patient's symptoms and drug history.

GG. Respondent failed to perform the requisite examinations to determine back pain. No neurological exam, no evaluation of range of motion, and no evaluation of functional ability was performed.

HH. The patient returned on May 13, 2013. Again, she paid $100 for the visit .

II. Respondent told the patient that she should still have Vicodin left from the last prescription. Respondent said that if she took too many pills and did not follow his prescription instructions, he was not going to give her the medication anymore.

Respondent told the patient that she could use less than four pills per day and that if she ran out in less than 30 days she was using too much. Respondent said that she had to wait for 30 days before her next visit and she agreed. She asked why he was getting so strict and Respondent said that she had not seen anything strict yet. He gave her a prescription of Vicodin extra strength 725/325. She asked whether she had to come every month to get a prescription. When asked if she could get a two-month supply he said "you're out of your mind." He stated this is a controlled substance and that she would only get what she needed and no more than that. He also stated that he does not give refills.

JJ. Respondent gave Patient C.M.B. a Vicodin ES refill with no examination.

KK. Although there was nothing in the patient's chart to review, Respondent recorded under review of systems that "I have reviewed the infection, surgical, family, genetic screening, social, drug allergy, food allergy, environment allergy, immunization, menstrual and pre."

LL. Again, no physical examination was performed.

MM. Again, there was no discussion regarding the patient's past drug use.

NN. Patient C.M.B. next presented to Respondent on July 3, 2013. She paid $100 for the visit and received a receipt for the payment. She told Respondent when she called, she was told that she could come in for her Vicodin.

OO. When asked about her pain, Patient C.M.B. said that she did not have pain but she wanted something to relax; something like what she had gotten before which was the Vicodin. Respondent said that Vicodin was for intractable pain. She responded that she was having a lot of stress with her daughter and wanted something to help her relax.

PP. Respondent said that she should take some medications and work on her stress level instead of taking narcotics. He explained that narcotics are a treatment for

pain. Any use other than that is a misuse of the medication and that it would not help her and actually might cause problems for her.

QQ. When the patient said that she had been taking this for a while, Respondent replied that she had told him that she had pain in her back and that's why he gave her the medication in the past. She clarified that she initially tried Vicodin for her pain but realized that it made her feel better, so she wanted to see if she could get some more to make her feel relaxed. Respondent said that he prescribed Vicodin for pain and not to help her relax and that's how people get into trouble when they use medications wrongly.

RR. Respondent recommended that they might try an antidepressant and that this might help her stress and function better. The patient mentioned Xanax or "something like that". Respondent said that Xanax is a tranquilizer and is not the best option for her to consider. Patient C.M.B. asked if she could get a prescription for Xanax and see if that makes her feel better.

SS. Respondent then agreed to give her a prescription for Xanax and stated that she did not need pain medication.

PATIENT P.P.

TT. Patient P.P. was at Respondent's office when a search warrant was conducted by members of various law enforcement agencies. She reported that she first started seeing Respondent sometime in 2012. She said that she was on Medi-Cal and Medicare at the time and does not know how much she paid for a medical visit. She gave her insurance information to her caregiver who, in turn, presented it to Respondent's office

UU. Patient P.P. stated that she was seen for pain underneath her right breast and it has resolved. Patient P.P. stated that Respondent did not perform a physical exam

or order prior records prior to prescribing medications for her. She does not recall which medications were prescribed. Respondent did not ask her what other medications she was taking prior to prescribing the pain medication.

VV. Patient P.P. further stated that she had been hospitalized last year for a drug overdose.

Patient T.M.

WW. Patient T.M. was Respondent's patient for approximately 10 years. She sees him for her annual checkup. She had seen him approximately six to eight times. Her husband, son, mother, and sister have also been treated by Respondent. Patient T.M. had medical insurance and she remitted a co-pay of $35.00 per visit when she presented to Respondent's office.

XX. On the day the search warrant was executed at Respondent's office, Patient T.M., was being seen for a headache, neck and shoulder pain, and a general checkup. She had had some of these symptoms for the last 6 years. She states that Respondent performs a physical exam and checks for areas of concern for pain. She states that Respondent had prescribed Motrin and a muscle relaxant for her pain in the past. She has never been prescribed Vicodin or anything stronger by Respondent. He is the only physician that she sees.

YY. Patient T.M. waited for approximately 20-30 minutes in the lobby before being seen. She stated that Respondent performed a physical exam and was in the room with her approximately ten minutes for her visits. He never referred her for physical therapy or x-rays; he never instructed her where to fill her prescriptions. Patient T.M. denied any drug or alcohol abuse history.

PATIENT A.G.

ZZ. Patient A.G. is a 43-year-old female who, during the 10 month period from April 13, 2011, through February 11, 2012, received an average of 12 narcotic medications per day from Respondent. The drugs included hydrocodone, clonazepam, and triazolam.

AAA. The records prepared and maintained by Respondent did not contain documentation of any adequate medical history or the performance of an adequate physical examination.

FIRST CAUSE FOR DISCIPLINE

(Excessive Prescribing)

58. Respondent is subject to disciplinary action under Business and Professions Code section 725 in that he excessively prescribed controlled substances and other dangerous drugs to M.G., C.B., J.M., A.C., C.M.B., P.P., T.M., A.G., and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, inclusive, above, as though fully set forth.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Without An Appropriate Physical Examination And Medical Indication)

59. Respondent is subject to disciplinary action under Business and Professions Code section 2242 in that he prescribed controlled substances and other dangerous drugs without an appropriate physical examination and medical indication to M.G., C.B., J.M., A.C., C.M.B., P.P., T.M., A.G. and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, inclusive, above, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Prescribing To Addicts)

60. Respondent is subject to disciplinary action under Business and Professions Code section 2241 in that he prescribed controlled substances and other dangerous drugs to individuals he knew or should have known were addicts, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, inclusive , above, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Applicable Drug Laws)

61. Respondent is subject to disciplinary action under section 2238, in connection with sections 2241, 2242, and 725; and Health and Safety Code sections 11152, 11153, and 11190, in that he violated laws pertaining to prescribing controlled substances and other dangerous drugs, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

62. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during the care, treatment and management of patients M.G., C.B., J.M., A.C., C.M.B., P.P., T.M., A.G., and others as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

B. The following acts and omissions, considered collectively and individually, constitute extreme departures from the standard of care:

1) Providing controlled and non-controlled medications to patients without a prescription, without proper documentation, and without appropriate safeguard.

2) Providing controlled and non-controlled medications obtained from deceased patients without adhering to applicable state and federal statutes, regulations and guidelines.

3) As to all patients presenting with complaints of back pain, providing inadequate management for such complaints.

4) Discharging patients from his practice without sufficient written

notification and without offering to refer the patient to another provider.

5) Failing to discard returned medications properly.

6) As to Patient M.G., Respondents overall care was well below the applicable standard of care.

7) As to Patient M.G., failing to completely and appropriately evaluate the patient's congestive heart failure.

8) As to Patient M.G., failing to evaluate and manage her elevated and, at times, highly elevated blood pressure.

9) As to Patient M.G., failing to evaluate and reevaluate pain treatment; to refer the patient to pain management/physical medicine or another appropriate subspecialist dealing with the specific pain that the patient had (and require this as a condition of treatment); and, failing to suggest or provide alternative non-addicting or less addicting medications as well as non-pharmaceutical treatments such as physical therapy.

10) As to Patient M.G. and, specifically, M.G.'s complaint of migraines, failing to evaluate with a thorough history and examination regarding this complaint, failing to consider imaging of the head when the headaches required long-term treatment with controlled substances, failing to consider and utilize additional management of the headaches including abortive and preventive strategic; and, failing to refer the patient for management assistance.

11) As to Patient C.M.B., failing to document an adequate history and/or physical exam in spite of opioid and Xanax prescriptions, and the chart documenting Review of System details and Physical Exam information on at least two visits—namely, May 13 and July 3, 2013.

12) As to Patient C.M.B., failing to take an adequate history and perform a proper physical examination prior to prescribing controlled substances; failing to monitor the patient; failing to examine the patient at the second and third visits; and, prescribing opiates and other controlled substances when suspicions of non-legitimate use were present; or, in the alternative, failing to document that he had done so.

13) As to Patient C.M.B., prescribing controlled substances without regular appointments and without fully and adequately evaluating the patient's complaints of pain.

14) As to Patient C.M.B., prescribing large doses of opioids without discussing the risks and benefits of this treatment or, in alternative, failing to document that he had done so.

15) As to Patient J.M., failing to evaluate and monitor the patient appropriately prior to and while prescribing opiates, the failure to monitor the patient for side effects and to perform a periodic, appropriate review of the use of opiates in this patient, the failure of enforcing consultation as a requirement of continued opiate prescribing, the prescribing of opiates and other controlled substances when suspicions of addiction were present, and the failure to discuss added risks to the patient of potential overdose and death when the Morphine Equivalent Dose exceeds 120 mg.

16) As to Patient J.M., failing to perform and document an adequate history and/or physical exam on multiple visits, failing to perform and document appropriate monitoring of long-term opioid treatment and the associated pain, and failing to taking an adequate history and performing an appropriate exam pertaining to the patient's liver disease.

17) As to Patient J.M., prescribing large dosages of opioids.

18) As to Patient J.M., failing to discuss the risks and benefits of the proposed treatment plan or, in the alternative, failing to document that he had done so.

19) As to Patient J.M., preparing a chart with unresolved conflicting information such as stating that the patient doesn't smoke, while stating he smokes a half pack per day.

20) As to Patient J.M., failing to provide adequate monitoring of a treatment plan involving large doses of opioids.

21) As to Patient J.M., failing to contact his prior treating physicians or failing to document that he had done so.

22) As to patient A.C., failing to take an appropriate history and perform an

adequate physical examination prior to prescribing controlled substances; failing to provide other options for the treatment of her chronic pain, failing to monitor her chronic opioid use; and, failing to evaluate further the need for opioid medications with imaging or an expert in the field.

23) As to Patient A.C., failing to document an adequate history and proper physical examination for a patient to whom he prescribed opiates and Soma.

SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

63. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts during his care, treatment and management of M.G., C.B., J.M., A.C., C.M.B., P.P., T.M., A.G., and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

B. The following acts and omissions constitute departures from the standard of care:

1) Providing controlled and non-controlled medications to patients without a prescription, without proper documentation, and without appropriate safeguard.

2) Providing controlled and non-controlled medications obtained from deceased patients without adhering to applicable state and federal statutes, regulations and guidelines.

3) Providing inadequate management for such complaints to patients presenting with chronic back pain.

4) Discharging patients from his practice without sufficient written notification and without offering to refer the patient to another provider.

5) Failing to discard returned medications properly.

6) As to Patient M.G., Respondents overall care was well below the

applicable standard of care.

7) As to Patient M.G., failing to completely and appropriately evaluate the patient's congestive heart failure.

8) As to Patient M.G., failing to evaluate and manage her elevated and, at times, highly elevated blood pressure.

9) As to Patient M.G., failing to evaluate and reevaluate pain treatment; to refer the patient to pain management/physical medicine or another appropriate subspecialist dealing with the specific pain that the patient had (and require this as a condition of treatment); and, failing to suggest or provide alternative non-addicting or less addicting medications as well as non-pharmaceutical treatments such as physical therapy.

10) As to Patient M.G. and, specifically, M.G.'s complaint of migraines, failing to evaluate with a thorough history and examination regarding this complaint, failing to consider imaging of the head when the headaches required long-term treatment with controlled substances, failing to consider and utilize additional management of the headaches including abortive and preventive strategic; and, failing to refer the patient for management assistance.

11) As to Patient C.M.B., failing to document an adequate history and/or physical exam in spite of opioid and Xanax prescriptions, and the chart documenting Review of System details and Physical Exam information on at least two visits—namely, May 13 and July 3, 2013.

12) As to Patient C.M.B., failing to take an adequate history and perform a proper physical examination prior to prescribing controlled substances; failing to monitor the patient; failing to examine the patient at the second and third visits; and, prescribing opiates and other controlled substances when suspicions of non-legitimate use were present; or, in the alternative, failing to document that he had done so.

13) As to Patient C.M.B., prescribing controlled substances without regular appointments and without fully and adequately evaluating the patient's complaints of pain.

14) As to Patient C.M.B., prescribing large doses of opioids without

discussing the risks and benefits of this treatment or, in alternative, failing to document that he had done so.

15) As to Patient J.M., failing to evaluate and monitor the patient appropriately prior to and while prescribing opiates, the failure to monitor the patient for side effects and to perform a periodic, appropriate review of the use of opiates in this patient, the failure of enforcing consultation as a requirement of continued opiate prescribing, the prescribing of opiates and other controlled substances when suspicions of addiction were present, and the failure to discuss added risks to the patient of potential overdose and death when the Morphine Equivalent Dose exceeds 120 mg.

16) As to Patient J.M., failing to perform and document an adequate history and/or physical exam on multiple visits, failing to perform and document appropriate monitoring of long-term opioid treatment and the associated pain, and failing to take an adequate history and performing an appropriate exam pertaining to the patient's liver disease.

17) As to Patient J.M., prescribing large dosages of opioids.

18) As to Patient J.M., failing to discuss the risks and benefits of the proposed treatment plan or, in the alternative, failing to document that he had done so.

19) As to Patient J.M., preparing a chart with unresolved conflicting information such as stating that the patient doesn't smoke, while stating he smokes a half pack per day.

20) As to Patient J.M., failing to provide adequate monitoring of a treatment plan involving large doses of opioids.

21) As to Patient J.M., failing to contact his prior treating physicians or failing to document that he had done so.

22) As to patient A.C., failing to take an appropriate history and perform an adequate physical examination prior to prescribing controlled substances; failing to provide other options for the treatment of her chronic pain, failing to monitor her chronic opioid use; and, failing to evaluate further the need for opioid medications with imaging or an

expert in the field.

23) As to Patient A.C., failing to document an adequate history and proper physical examination for a patient to whom he prescribed opiates and Soma.

SEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

65. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (d), in that he demonstrated a lack of skill, knowledge and expertise to discharge the duties, functions, and responsibilities of a physician and surgeon during the care, treatment and management of M.G., C.B., J.M., A.C., C.M.B, P.P., T.M., A.G., and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

66. Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to maintain adequate and accurate records relating to the provision of medical services to M.G., C.B., J.M., A.C., C.M.B, P.P., T.M., A.G.,. and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

67. Respondent is subject to disciplinary action under Business and Professions Code section 2234, in that he committed unprofessional conduct, generally, during the care, treatment and management of M.G., C.B., J.M., A.C., C.MB.., P.P., T.M., A.G., and others, as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 15 through 57, above, as though fully set forth.

TENTH CAUSE FOR DISCIPLINE

(Criminal Conviction)

68. Respondent is subject to disciplinary action under Business and Professions Code section 2236 in that he has sustained a criminal conviction for an offense substantially related to the qualifications, functions or duties of a physician and surgeon, as follow:

A. On or about June 25, 2014, in the matter of the *People of the State of California v. Oliver Cheng –Tung Tsai*, Case No. 4JB03972, Respondent was charged in each of Counts 1, 2 and 3 with unlawfully issuing prescriptions for Vicodin, in violation of Health and Safety Code section 11153, subdivision (a), a misdemeanor.

B. On July 11, 2014, Respondent entered not guilty pleas to the charges.

C, On September 24, 2014, pursuant to a negotiated plea agreement, Respondent withdrew his previously entered not guilty plea to Count 3 and entered a plea of *nolo contendere.*

D. Proceedings were suspended. Respondent was placed on summary probation for 24 months. As part of the negotiated plea agreement, Counts 1 and 2 were dismissed.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's No. A49033, issued to Oliver Cheng-Tung Tsai, M.D.

2.. Revoking, suspending or denying approval of Oliver Cheng-Tung Tsai, M.D.'s authority to supervise physician assistants, pursuant to Business and Professions Codes section 3527;

3. Ordering Oliver Cheng-Tung Tsai, M.D., if placed on probation, to pay the Medical Board the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: April 2, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs

State of California

Complainant

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EXHIBIT B

CEASE PRACTICE ORDER

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Decision and Order against:	)	
	)	
OLIVER CHENG-TUNG TSAI, M.D.	)	Case No. 13-2012-222272
	)	
Physician's & Surgeon's Certificate No. A49033	)	
	)	
	)	
Respondent.	)	

CEASE PRACTICE ORDER

In the Medical Board of California (Board) Case No. 13-2012-222272, the Board issued a Decision adopting a Stipulated Settlement and Disciplinary Order, which became effective October 28, 2016. In the Board's Order, Physician's and Surgeon's License No. A49033, issued to OLIVER CHENG-TUNG TSAI, M.D., was revoked, revocation stayed and Respondent was placed on probation for five years with terms and conditions.

Probationary Condition No. 6 requires Respondent, within 60 calendar days from the effective date of the decision, to enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine (PACE Program). Respondent was also required to complete the program within six months after his/her initial enrollment. Condition No. 6 provides that, if respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within three days after being notified by the Board or its designee that respondent failed to complete the clinical training program.

Respondent has failed to successfully complete the clinical training program, as mandated in the above Decision and Order. Accordingly, within three days from the date of this Order, Respondent, OLIVER CHENG-TUNG TSAI, M.D., is prohibited from engaging in the practice of medicine. Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation.

IT IS SO ORDERED July 11, 2017 at 5:00 p.m.

KIMBERLY KIRCHMEYER
Executive Director